4. RESIDENT ASSESSMENT PROTOCOL: COMMUNICATION

I. PROBLEM

Good communication enables residents to express emotion, listen to others, and share information. It also eases adjustment to a strange environment and lessens social isolation and depression.

EXPRESSIVE communication problems include changes/difficulties in: speech and voice production, finding appropriate words, transmitting coherent statements, describing objects and events, using nonverbal symbols (e.g., gestures), and writing. RECEPTIVE communication problems include changes/difficulties in: hearing, speech discrimination in quiet and noisy situations, vocabulary comprehension, vision, reading, and interpreting facial expressions.

When communication is limited, assessment focuses on reviewing several factors: underlying causes of the deficit, the success of attempted remedial actions, the resident's ability to compensate with nonverbal strategies (e.g., ability to visually observe nonverbal signs and signals), and the willingness and ability of staff to engage with residents to ensure effective communication. As language use recedes with dementia, both the staff and the resident must expand their nonverbal communication skills -- one of the most basic and automatic of human abilities. Touch, facial expression, eye contact, tone of voice, and posture all are powerful means of communicating with the demented resident, and recognizing and using all practical means is the key to effective communication.

II. TRIGGERS

Potential for improved communication suggested if one or more of following present:

- Hearing Problem
  [C1 = 1, 2, 3]
- Problem Making Self Understood*
  [C4 = 1, 2, 3]
- Problem Understanding Others
  [C6 = 1, 2, 3]

* **Note:** Thise code also triggers on the Cognitive Loss/Dementia RAP.

III. GUIDELINES

The communication trigger suggests residents for whom a corrective communication treatment program may be beneficial. Specify those residents with potentially correctable problems. An effective review requires a special effort by staff to overcome any preconceived notions or

fixed perceptions they may have about the resident's probable responsiveness to treatment. These perceptions may be based on the failure of prior treatment programs, as well as on assumptions that may not have been recently tested about the resident's unwillingness to begin a corrective program.

Review items listed on the RAP KEY as follows:

Confounding Problems

As these confounding problems lessen or further decline is prevented, the resident's communication abilities should be reviewed.

Components of Communication

Details of resident strengths and weaknesses in understanding, hearing, and expression are the direct or indirect focus of any treatment program.

Factors to Review for Possible Relationship to Communication Problems:

- For chronic conditions that are unlikely to improve, consider communication treatments or interventions that might compensate for losses (e.g., for moderately impaired residents with Alzheimer's, the use of short, direct phrases and tactile approaches to communication can be effective).
- Are there acute or transitory conditions which, if successfully resolved, may result in improved ability to communicate?
- Are medications in use that could cause or complicate communication deficits, where titration or substitution may result in improved ability to communicate?
- Are opportunities to communicate limited in ways that could be remedied -- e.g., availability of partners?

Clarifying Issues:

Treatment/Evaluation History

- Has resident received an evaluation by an audiologist or speech-language pathologist? How recently?
- Has the resident's condition deteriorated since the most recent evaluation?
- If such an evaluation resulted in a plan of care, has it been followed as specified?

4. COMMUNICATION RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

Potential for improved communication suggested if one or more of following present:

- Hearing Problem
  [C1 = 1, 2, 3]
- Problem Making Self Understood
  [C4 = 1, 2, 3]
- Problem Understanding Others*
  [C6 = 1, 2, 3]

* **Note:** Thise code also triggers on the Cognitive Loss/Dementia RAP.

GUIDELINES

Confounding problems that may require resolution:

- Decline in Cognitive Status **[B6]**
- Increased Mood problems **[E3]**
- Decline in ADL Status **[G9]**

Components of communication to be considered:

- Hearing **[C1]**.
- Communication Devices/Modes of Expression **[C2, C3]**
- Decline in Communication/Hearing **[C7]**
- Medical Status of Ear – Discharges, Cerumen Accumulation, Hearing Changes **[from record or exam]**
- Vision **[D1]**

Factors to be reviewed for possible relationship to communication problems:

- **Chronic Conditions** – Alzheimer's or Other Dementia **[I1q, I1u]**, Aphasia **[I1r]**, CVA **[I1t]**, Parkinson's **[I1y]**, Psychiatric Disorders **[I1dd to I1gg]**, Asthma **[I1hh]**, Emphysema/COPD **[I1ii]**, Cancer **[I1pp]**
- **Transitory Conditions** – Delirium **[B5]**, Infections **[I2]**, Acute Episode **[J5b]**
- **Medications** – Psychotropic **[04a-d]**, Narcotics, Parkinson's Meds, Gentamycin, Tobramycin, Aspirin Toxicity **[from record]**
- **Opportunities to Communicate** – Quality/Quantity of Communication is (or is not) Commensurate with Apparent Ability to Communicate **[staff judgement]**

Clarifying issues to be considered:

- Memory **[B2, B3]**.
- Recent audiology/language pathology evaluation **[P1ba; from record]**
- Resident's condition deteriorated since last assessment **[Q2]**

5. RESIDENT ASSESSMENT PROTOCOL: ACTIVITIES OF DAILY LIVING - FUNCTIONAL REHABILITATION POTENTIAL

I. PROBLEM

Personal mastery of ADL and mobility are as crucial to human existence in the nursing facility as they are in the community. The nursing facility is unique only in that most residents require help with self-care functions. ADL dependence can lead to intense personal distress -- invalidism, isolation, diminished self-worth, and a loss of control over one's destiny. As inactivity increases, complications such as pressure ulcers, falls, contractures, and muscle wasting can be expected.

The ADL RAP assists staff in setting positive and realistic goals, weighing the advantages of independence against risks to safety and self-identity. In promoting independence staff must be willing to accept a reasonable degree of risk and active resident participation in setting treatment objectives.

Rehabilitative goals of several types can be considered:

- To restore function to maximum self-sufficiency in the area indicated;
- To replace hands-on assistance with a program of task segmentation and verbal cueing;
- To restore abilities to a level that allows the resident to function with fewer supports;
- To shorten the time required for providing assistance;
- To expand the amount of space in which self-sufficiency can be practiced;
- To avoid or delay additional loss of independence; and
- To support the resident who is certain to decline in order to lessen the likelihood of complications (e.g., pressure ulcers and contractures).

II. TRIGGERS

The two MDS trigger categories (A and B) suggest the types of residents for who special care interventions may be most important. Such residents may have either the need and potential to improve (Rehabilitation) or the need for services to prevent decline (Maintenance).

ADL TRIGGERS A (Rehabilitation)

Rehabilitation/restorative plans suggested if one or more of following present:

- Bed Mobility - Not Independent
  [G1aA = 1-4][(a)]
- Transfer - Not Independent
  [G1bA = 1-4]
- Walk in Room - Not Independent
  [G1cA = 1-4]

- Walk in Corridor - Not Independent
  [G1dA = 1-4]
- Locomotion on Unit - Not Independent
  [G1eA = 1-4]
- Locomotion off Unit - Not Independent
  [G1fA = 1-4]
- Dressing - Not Independent
  [G1gA = 1-4]
- Eating - Not Independent
  [G1hA = 1-4]
- Toilet Use - Not Independent
  [G1iA = 1-4]
- Personal Hygiene - Not Independent
  [G1jA = 1-4]
- Bathing - Not Independent
  [G2aA = 1-4]
- Resident believes he/she is capable of increased independence in at least some ADLs
  [G8a = checked]
- Staff believe resident is capable of increased independence in at least some ADLs
  [G8b = checked]

ADL TRIGGERS B (Maintenance)

Maintenance/Complication Avoidance Plan Suggested If: [**Note:** When both triggers present (A & B), B takes precedence in the RAP Review]

- No ability to make decisions
  [B4 = 3][(b)]

[(a)] **Note:** Codes 2,3, and 4 also trigger on the Pressure Ulcer RAP.
[(b)] **Note:** This code also triggers on the Cognitive Loss/Dementia RAP.

III. GUIDELINES

Base an approach to a resident's ADL difficulty on clinical knowledge of:

- The causes of dependence;
- The expected course of the problem(s); and
- Which services work or do not work.

The MDS goal is to assist the clinician in identifying residents for whom rehabilitative/restorative goals can be reasonably established. Many ADL-restricted residents can regain partial ability for self-care. Certain types of disease-generated losses will respond

to therapy. In addition, the removal of inappropriate restraints and the close monitoring of potentially toxic medications can often result in increased functioning.

Use the items in the ADL RAP KEY to consider the resident's risk of decline and chance of rehabilitation. Responses to these items permit a focused approach to specific ADL deficits (i.e., selecting and describing the specific ADL areas where decline has been observed or improvement is possible). The first thing that needs to be considered is the possible presence of ***confounding problems*** that may require resolution before rehabilitation goals can be reasonably attempted.

The second task is to clarify the resident's potential for improved functioning. The clinician might find the following sequence of questions useful in initiating an evaluation:

- Does the resident have the ability to learn? To what extent can the resident call on past memory to assist in current problem-solving situations?
- What is the resident's general functional status? How disabled is the resident, and does status vary?
- Is mobility severely impaired?
- Is trunk, leg, arm and/or hand use severely impaired?
- Are there distinct behavioral problems?
- Are there distinct mood problems?
- Is the resident motivated to work at a rehabilitative program?

Where rehabilitation goals are envisioned, use of the ***ADL Supplement*** will help care planners to focus on those areas that might be improved, allowing them to choose from among a number of basic tasks in designated areas. Part 1 of the Supplement can assist in the evaluation of all residents triggered into the RAP. Part 2 of the Supplement can be helpful for residents with rehabilitation potential (ADL Triggers A), to help plan a treatment program.

ADL SUPPLEMENT
(Attaining maximum possible Independence)

PART 1: ADL Problem Evaluation INSTRUCTIONS: For those triggered - In areas physical help provided, indicate reason(s) for this help.	DRESSING	BATHING	TOILETING	LOCOMOTION	TRANSFER	EATING
Mental Errors: Sequencing problems, incomplete performance, anxiety limitations, etc. **Physical Limitations:** Weakness, limited range of motion, poor coordination, visual impairment, pain, etc. **Facility Conditions:** Policies, rules, physical layout, etc.						

PART 2: Possible ADL Goals				If wheelchair, check: ☐		
INSTRUCTIONS: For those considered for rehabilitation or decline prevention treatment - Indicate specific type of ADL activity that might require: 1. Maintenance to prevent decline. 2. Treatment to achieve highest practical selfsufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in).	Locates/ selects/ obtains clothes	Goes to tub/ shower	Goes to toilet (include commode/ urinal at night)	Walks in room/ nearby ☐	Positions self in preparation	Opens/ pours/ unwraps/ cuts etc.
	Grasps/puts on upper/ lower body	Turns on water/ adjusts temperature	Removes/ opens clothes in preparation	Walks on unit ☐	Approaches chair/bed	Grasps utensils and cups
	Manages snaps, zippers, etc.	Lathers body (except back)	Transfers/ positions self	Walks throughout building (uses elevator) ☐	Prepares chair/bed (locks pad, moves covers)	Scoops/ spears food (uses fingers when necessary)
	Puts on in correct order	Rinses body	Eliminates into toilet	Walks outdoors ☐	Transfers (stands/sits/ lifts/turns)	Chews, drinks, swallows
	Grasps, removes each item	Dries with towel	Tears/uses paper to clean self	Walks on uneven surfaces ☐	Repositions/ arranges self	Repeats until food consumed
	Replaces clothes properly	Other	Flushes	Other ☐	Other	Uses napkins, cleans self
	Other		Adjusts clothes, washes hands			Other

5. ADL FUNCTIONAL/REHABILITATION POTENTIAL RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

ADL TRIGGERS A (Rehabilitation)

Rehabilitation/restorative plans suggested if one or more of following present:

- Bed Mobility – Not Independent **[G1aA = 1-4]**[(a)]
- Transfer – Not Independent **[G1bA = 1-4]**
- Walk in Room – Not Independent **[G1cA = 1-4]**
- Walk in Corridor – Not Independent **[G1dA = 1-4]**
- Locomotion On Unit – Not Independent **[G1eA = 1-4]**
- Locomotion Off Unit – Not Independent **[G1fA = 1-4]**
- Dressing – Not Independent **[G1gA = 1-4]**
- Eating – Not Independent **[G1hA = 1-4]**
- Toilet Use – Not Independent **[G1iA = 1-4]**
- Personal Hygiene – Not Independent **[G1jA = 1-4]**
- Bathing – Not Independent **[G2A = 1-4]**
- Resident Believes He/She is Capable of Increased Independence in at Least Some ADLs **[G8a = checked]**
- Staff Believes Resident is Capable of Increased Independence in at Least Some ADLs **[G8b = checked]**

ADL TRIGGERS B (Maintenance)

Maintenance/complication avoidance plan suggested if: [**Note:** When both triggers present (A & B), B takes precedence in the RAP Review]

- Severely impaired decision-making **[B4 = 3]**[(b)]

(a) **Note:** Codes 2, 3 and 4 also trigger on the Pressure Ulcer RAP.

(b) **Note:** This code also triggers on the Cognitive Loss/Dementia RAP.

GUIDELINES

Confounding problems that may require resolution:

- Delirium **[B5]**
- Persistent Mood Problem **[E2]**
- Decline in Mood **[E3]**
- Daily Behavioral Symptoms **[E4]**
- Decline in Behavior **[E5]**
- Unstable/Acute Health Problem **[J5a,b]**
- Use of Psychoactive Medications **[O4a,b,c,d]**
- Resident Status Deteriorated Since Last Assessment **[Q2]**

Clarifying issues to be considered:

- Ability to Make Decisions **[B4]**
- Prior Improvement in Cognition, Mood, Behavior, or ADLs **[B6, E3, E5, G9]**
- Communication **[C]**
- Vision **[D]**
- Test for Balance, Functional Limitation in Range of Motion **[G3, G4]**

Complete ADL Supplement Part I for all triggered residents (see RAI training manual).

For a resident with rehabilitation potential, complete ADL Supplement Part 2 (see RAI training manual).

- Staff/Resident Believe Resident Could Be More Independent **[G8a,b]**

6. RESIDENT ASSESSMENT PROTOCOL: URINARY INCONTINENCE AND INDWELLING CATHETER

I. PROBLEM

Urinary incontinence is the inability to control urination in a socially appropriate manner. Nationally, approximately 50% of nursing facility residents are incontinent. Incontinence causes many problems, including skin rashes, falls, isolation, and pressure ulcers, and the potentially troubling use of indwelling catheters. In addition, continence is often an important goal to many residents, and incontinence may affect residents' psychological well-being and social interactions. Urinary incontinence is curable in many elderly residents but realistically not all will benefit from an evaluation. Catheter use increases the risk of life-threatening infections, bladder stones and cancer. Use of catheters also contributes to patient discomfort and the needless use of toxic medications often required to treat the associated bladder spasms. For many (but not all) residents, urinary incontinence is curable, and safer and more comfortable approaches are often practical for residents with indwelling catheters.

This RAP, the purpose of which is to improve incontinence, goes far beyond bladder training. Even if a patient is not believed to be a candidate for bladder training, the assessment should still be done since many other treatable conditions may be found, the treatment of which will not only improve incontinence, but the overall quality of life for the patient.

The goal of this assessment is to detect reversible causes of incontinence, such as infections and medications, and situationally induced incontinence; to identify individuals whose incontinence is caused by harmful conditions such as bladder tumors or spinal cord diseases; and to consider the appropriateness of catheter use. Staff judgment is clearly required to realize these aims. Detailed instructions are provided to facilitate this clinical process.

Continence depends on many factors. Urinary tract factors include a bladder that can store and expel urine and a urethra that can close and open appropriately. Other factors include the resident's ability (with or without staff assistance) to reach the toilet on time (locomotion), his/her ability to adjust clothing so as to toilet (dexterity), cognitive function and social awareness (e.g., recognizing the need to void in time and in an appropriate place), and the resident's motivation. Fluid balance and the integrity of the spinal cord and peripheral nerves will also have an effect on continence. Change in any one of these factors can result in incontinence, although alterations in several factors are common before incontinence develops.

II. TRIGGERS

Incontinence care plan suggested if one or more of following present:

- Incontinent 2+ Times a Week
  [H1b = 2, 3 or 4]

- Use of External (Condom) Catheter
  [H3c = checked]
- Use of Indwelling Catheter
  [H3d = checked]
- Use of Intermittent Catheter
  [H3e = checked]
- Use of Pads/Briefs
  [H3g = checked]

III. GUIDELINES

For residents with incontinence (including those with condom catheters), all MDS items described in Section A should be addressed, unless exclusionary criteria have been met. If incontinence persists, complete Section B and, if necessary, Section C. For residents with indwelling catheters, first complete Sections A and B and then complete Section D.

A. ITEMS NECESSARY TO EVALUATE INCONTINENCE OR NEED FOR CATHETER

Review the reversible problems listed on the RAP KEY. Virtually all are easily diagnosed, and their treatment will improve not only incontinence but functional status as well. Also, most of these factors can be identified by a nurse, but some will take a physician's order to carry out.

UTI

Urinary tract infections are common causes of incontinence, especially new incontinence. Therefore, they should be looked for in all residents. If a clean catch urine is not feasible and the resident both has no memory recall and requires at least extensive assistance in self-transfer you may choose to forego catherization to obtain a specimen, since identification and treatment of UTIs in this population has not been shown to make a difference.

- Send a clean catch or sterile urine specimen for microscopic analysis. If >5 WBC are found, send a fresh and sterilely obtained specimen for urine culture. If UTI is found, consider treatment.
- For residents with an indwelling catheter, a new catheter should be sterilely inserted to obtain the specimen.

Fecal Impaction

Impaction is very common and can cause incontinence by preventing the bladder from emptying well. Thus, check for impaction in all residents who are incontinent.

- To find bowel impaction, insert a gloved finger into resident's rectum.

- The finding of no stool or small amount of soft stool indicates that impaction is unlikely to be the cause of incontinence. A record demonstrating that the resident has recently passed stool is not sufficient to rule out bowel impaction.

Delirium

If Present, This is the Most Important Problem - Often when delirium is treated, incontinence will resolve. In the meantime, regular toileting will help.

Lack of Toilet Access

Daily use of restraints can result in a resident's inability to get to the toilet; quick staff response is necessary. The toilet may also be too far away for a resident who does not get adequate warning (e.g., there may not be a toilet room near the activities room). Environmental modifications such as a bedside commode, urinal, or a room closer to the toilet can be useful. To remain continent, residents may also require more staff support, such as more timely responses to requests for assistance.

Immobility

Immobility may correlate with incontinence. Improving the resident's ability in transferring, locomotion and toileting will often reduce incontinence, as will providing timely staff assistance when needed.

Depression

Severe depression can result in loss of the motivation to stay dry. Prompted toileting is often helpful as a means of positive reinforcement.

Congestive Heart Failure (CHF) or Pedal Edema

CHF and pedal edema are especially troublesome when the resident is lying down: diuresis overwhelms the bladder. Treatment of these conditions is not difficult and will improve both incontinence and functional status.

Recent Stroke

Once the resident is stable, delirium has cleared, and locomotion has improved, continue workup if incontinence persists. Most stroke patients are continent at this point.

Diabetes Mellitus

Diabetes with persistently high blood sugar causes fluid loss that can cause or worsen incontinence. Treatment will improve incontinence and functional status.

Medications

Many medications can affect the bladder or urethra and result in incontinence. Physicians would usually discontinue suspect medication if possible, weighing the risks and benefits of doing so. For instance, where a calcium channel blocker is used for mild hypertension, another medication might be easily substituted; a medication for arrhythmia, however, might not have an appropriate substitute.

- Review all medications - regularly prescribed, occasional or "PRN", and any nonprescribed ("over-the-counter") medications.

Medications that can affect continence include the following classes and types of drugs:

1. Diuretics, especially those that act quickly, such as furosemide (Lasix), bumetanide (Bumex), and metolozone (Zaroxylyn), and, less frequently, thiazide agents such as hydrochlorothiazide.

2. Sedative hypnotics, i.e., sleeping pills and antianxiety drugs such as diazepam (Valium), lorazepam, Xanax, Halcion, and Dalmane.

3. Any drug with anticholinergic properties:

    - Antipsychotics (e.g., Haldol, Mellaril)
    - Antidepressants (e.g., Elavil, Triavil)
    - Narcotics (e.g., Morphine, Dilaudid, Darvon)
    - Medication for Parkinson's disease (except Sinemet and Deprenyl)
    - Disopyramide
    - Antispasmodics (e.g., Donnatal, Bentyl)
    - Antihistamines (e.g., medications for colds)

4. Calcium channel blockers (e.g., verapamil, nimodipine, nicardipine, nifedipine, and diltiazem).

5. Drugs that affect the sympathetic nervous system:

    - Alpha blockers (e.g., prazosin and phenoxybenzamine)
    - Alpha stimulants (e.g., ephedrine, pseudoephedrine, phenylpropanolamine, and nosedrops)

B. OTHER POTENTIAL CAUSES OR FACTORS CONTRIBUTING TO INCONTINENCE OR USE OF CATHETERS

Much of the information asked for above will appear in a completed MDS. However, other items of information should be obtained and reviewed if incontinence persists. Identification and treatment of these factors will frequently not only improve incontinence,

but may prevent further deterioration such as paralysis. However, in the resident who both has no memory recall, requires at least extensive assistance in self-transfer, and is free of related pain, there is, as of yet, no evidence that identification and treatment of such factors would benefit the resident.

Pain

Pain in the bladder, related to urination, is a distinctly rare and abnormal symptom in the incontinent patient, and often indicates another pathological process, which may be treatable. Physician evaluation is recommended.

Excessive or Inadequate Urine Output

If daily urine output is less than 1 liter, incontinence may worsen because of very strong, concentrated urine. A daily output over 1.5 liters can overwhelm the bladder. If present, the identification of the underlying cause of the high urine output (e.g., diabetes, high calcium, or excessive fluid intake) is required before restricting fluids.

- The amount of fluid excreted daily should be measured for 1 to 2 days. This can be done using a voiding record or, if patient is severely incontinent, by inserting a *temporary* catheter.

Atrophic Vaginitis

Caused by reduced amount of the female hormone estrogen, this condition causes or contributes to incontinence in many women.

- Examine vagina for evidence of estrogen deficiency.

Optimally, a pelvic exam checks for signs of atrophic vaginitis.

If a resident is impaired, or appropriate equipment is not readily available, an exam may be done in the resident's bed by spreading the labia and looking inside for redness, dryness, pinpoint hemorrhages, or easy bleeding.

- Pain or irritation during the insertion of a catheter is another useful sign of the condition (catheterization normally may be uncomfortable, but should not be painful).
- Atrophic vaginitis can be treated with a low dose of oral conjugated estrogens. Contraindications to estrogen therapy include a history of breast or endometrial cancer.

Abnormal Lab Values

Several conditions detectable only by laboratory tests can cause incontinence. These include high blood calcium or glucose and Vitamin B12 deficiency. It is also important to check the blood urea nitrogen (BUN) or creatinine because some causes of incontinence

also can damage the kidneys. All of these tests should have been done within the last 60 days, except the B12, which should have been checked within the past 3 years.

Serious Conditions that Cause or Accompany Incontinence (to be Considered by Primary Doctor)

A doctor or a nurse practitioner can identify potentially life-threatening conditions that cause or accompany urinary incontinence. These include bladder cancer or bladder stones, prostate cancer, spinal cord or brain lesions (such as slipped discs and metastatic tumors), poor bladder compliance, and tabes dorsalis.

- Bladder cancer or stones are suggested by the presence of any amount of blood in the urine (even in microscopic amounts) without evidence of UTI. To investigate for bladder cancer, the first morning urine is sent for 2 or 3 days for cytology examinations. Residents more likely to have bladder cancer are men, smokers, and those with suprapubic pain or discomfort, a history of work exposure to certain dyes, or recent onset of urge incontinence. The physician will decide who is worked up or referred to an urologist.
- Suspected prostate cancer can be detected by a rectal exam.
- Spinal cord diseases are detected by a neurological exam.
- Decreased bladder compliance can result in damage to the kidneys and should be suspected in residents with a history of conditions that result in decreased bladder compliance (pelvic radiation therapy, abdominal/pelvic resection, radical hysterectomy or prostatectomy, or spinal cord disease).
- Another cause of incontinence is tabes dorsalis (an advanced stage of syphilis), which is treatable with antibiotics.

C. FINAL EVALUATION IF INCONTINENCE PERSISTS

After the above causes of easily treatable incontinence have been eliminated and most serious underlying conditions have been investigated, conclude the evaluation with an assessment of the four causes of incontinence that are due to abnormalities within the bladder itself. The following section first describes these abnormalities and then describes the tests to detect their presence. A variety of treatment options are available for each type of incontinence, including treatment and care plans appropriate for every resident. In each case, the care plan can be tailored to the needs and characteristics of the resident with dementia, immobility, etc. Notably, bladder training and medications have been shown to significantly improve incontinence in even severely demented residents. The options are discussed in full detail in the educational material.

Exclusions - Although demented residents have been shown to benefit from targeted therapy, certain patients have a low probability of responding. Therefore, if a resident has no memory recall, is extensively dependent in self-transfer, and the facility's ability to toilet the resident on a regular schedule is imited, then the patient may not benefit from this part of the evaluation, and should be managed with pads, frequent turning and changing, or external catheters. Indications for an indwelling catheter are: the resident is in a coma or

has terminal illness, a stage 3 or 4 pressure ulcer in an area affected by the incontinence, untreatable urethral blockage, the need for exact measurement of urine output, a history of being unable to void after having a catheter removed in the past, or a resident with quad/paraplegia who failed a past attempt to remove a catheter.

The bladder abnormalities can be simply understood: either (1) the bladder contracts when it should not ("uninhibited bladder"), abruptly soaking the patient ("urge incontinence"); or (2) the bladder fails to contract when it should ("atonic" or underactive bladder), so that urine builds up and spills over as "overflow incontinence." Alternatively the urethra, through which the bladder empties, is either (3) blocked by an obstruction (e.g., a large prostate) or (4) unable to close tightly enough ("stress incontinence").

By doing a "stress test" and measuring the amount of urine that remains in the bladder after voiding (Post Void Residual -- PVR) these conditions can be separated: the uninhibited bladder generally has little residual urine (<100 ml) and a negative stress test, while the atonic bladder has a much larger residual (e.g., >400 ml). Women with stress incontinence (it is rare in men) have <100 ml residual urine and a positive stress test. Men with a blocked urethra (rare in women) have >100 ml residual urine and a negative stress test.

Post-Void Residual (PVR)

The PVR (post-void residual) is the amount of urine left in the bladder after a void. Research has shown that many elderly people have large amounts left in the bladder after a void, even though they demonstrate no signs of this. That is, they do not feel full or uncomfortable, have good urine output, and do not seem to have a large bladder by palpation or percussion. Also, in men, a high PVR can signal a variety of problems, and in both men and women, knowledge of the PVR can help guide the selection of medication. Therefore, a PVR should be determined in all patients who reach this point of the evaluation. In some cases, a physician's order may be necessary to perform a PVR. If the physician chooses not to allow this, it should be documented in the chart.

- When the resident feels relatively full, he/she should void as normally as possible into a commode, bedpan, urinal, or a toilet equipped with a collection device (hat). Measure volume voided. Within 15 minutes of voiding, under sterile conditions, insert a nonpermanent catheter to measure the residual volume (PVR). Adding the volume voided to PVR gives the Total Bladder Volume (TBV).

Attention to several points will ensure that the test is done correctly. First, if the resident cannot void intentionally, do the test after an episode of incontinence. Second, after allowing the urine to drain, apply gentle pressure with your hand to the abdomen to increase the drainage. When the urine has stopped draining, withdraw the catheter slowly, continuing to press on the lower abdomen. If possible, have the resident sit up during the catheter withdrawal. Under sterile conditions, the risk of causing an infection is under 3%. Residents with known valvular heart disease (who receive antibiotic prophylaxis for dental work) probably should receive a dose of antibiotics before the PVR is checked.

Kidney Ultrasound Test for Men with a PVR Greater than 100 ml

- Ultrasound of the kidneys is indicated in male residents with a PVR greater than 100 ml to rule out hydronephrosis (inability of the kidneys to drain properly), which could be due to bladder obstruction and result in preventable kidney damage.

This test has no risks (compared to the risk of the dye injection in an IVP). Evidence of urine backing into the kidneys strongly suggests the need for urologic referral; if this is not done, the resident needs chronic indwelling catheterization.

Bladder Stress Test for Female Patients

- ***Bladder Stress Test -*** When the resident has a relatively full bladder, *but not a strong urge to void*, have her stand or assume as upright a position as possible, relax, and cough vigorously or strain. The test is positive if there is immediate leakage similar in volume and circumstance to usual incontinence. The stress test is negative if there is a delay of more than 5 seconds, no leakage, or leakage of only a few drops, or if it is dissimilar to the usual volume and circumstance of leakage.
- Measure void plus PVR as described above (i.e., calculate Total Bladder Volume).
- ***Repeat Stress Test -*** If the bladder stress test is negative AND the Total Bladder Volume is less than 200 ml, another test is needed for verification. Insert a sterile catheter into the bladder (preferably do this while the catheter for PVR measurement is still in the bladder) and fill it with at least 200 ml of sterile water, if possible. Remove the catheter, have the patient stand up (if possible), and repeat the stress test as above.

D. FINAL EVALUATION FOR RESIDENTS WITH INDWELLING CATHETERS

After the resident with an indwelling catheter has been treated for infection and all the other treatable conditions listed above, a voiding trial can be attempted -- unless the resident has terminal illness, stage 3 or 4 pressure ulcers, or untreatable urethral blockage. This trial may reveal that the catheter is not necessary after all.

Exclusions - The resident is in a coma or has terminal illness, a stage 3 or 4 pressure ulcer in an area affected by the incontinence, untreatable blockage, the need for exact measurement of urine output, a history of being unable to void after having a catheter removed in the past, or a resident with quad/paraplegia who failed a past attempt to remove a catheter.

- If appropriate, institute a voiding trial.

(1) Before removing the catheter, record urine output every 6 hours for one or two days. Use this record to plan when to remove the catheter so that the expected urine will not be over 800 mls during the time of the voiding trial.

(2) Remove catheter and observe. For example, if the resident usually puts out 500 ml on the day shift, remove the catheter at the beginning of that shift and observe; if resident has not voided by the end of the shift, wait until the volume gets higher, but do not exceed a volume of 800 ml.

(3) If resident is able to void, check the PVR, as detailed in **Section C**.

- If volume is greater than 400 ml, reinsert indwelling catheter permanently or until resident can be referred to a urologist.
- If PVR is between 100 and 400 ml, observe resident carefully as urinary retention may redevelop over a few days to a few weeks. If not, check for presence of incontinence: if present, complete **Section C** (above).
- If PVR is less than 100 ml, check for presence of incontinence; if present, complete **Section C** (above).

(4) If resident has not voided by the time the expected volume is 800 ml, and there is no sensation of fullness, no urge to void, and no void, reinsert an indwelling catheter and record the volume. Residents who fail the voiding trial need either urologic referral, if appropriate, or permanent catheterization.

(5) If the resident has no memory recall, is unable to transfer independently, and has incontinence that is resistant to all therapy for more than 2 weeks after removing the catheter, a catheter may be reinserted if deemed appropriate by the staff.

6. URINARY INCONTINENCE AND INDWELLING CATHETER RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

Incontinence care plan suggested if one or more of following present:

Incontinent 2+ Times a Week
[H1b = 2, 3 or 4]

Use of External (Condom) Catheter
[H3c = checked]

Use of Indwelling Catheter
[H3d = checked]

Use of Intermittent Catheter
[H3e = checked]

Use of Pads/Briefs
[H3g = checked]

GUIDELINES

Possible reversible problems to be reviewed in evaluating incontinence or need for catheter:

- **Conditions:** Delirium **[B5]**, Fecal Impactions **[H2d]**, Depression **[I1ee]**, UTI **[I2j],** Edema **[J1g]**.
- **Environment:** Locomotion **[G1c,d,e,f],** Lack of access to toilet, Barriers **[observation],** Restraints **[P4].**
- **Diagnoses:** Diabetes **[I1a],** CHF **[I1f],** CVA **[I1t],** Parkinson's **[I1y].**
- **Medications:** Diuretics **[O4e],** Parkinson's meds, Disopyramide, Antispasmodics, Antihistamines, Drugs that stimulate or block sympathetic nervous system, Calcium channel blockers (verapamil, nifedipine, diltiazem), Narcotics **[from record].**
- **Psychoactive Medications:** Anti-psychotics, Antianxiety, Anti-depressants, Hypnotics, **[O4a,b,c,d].**

Other potential factors contributing to incontinence or use of catheter:

- **Conditions:** Pain **[J2];** Excessive or inadequate urine output, Atrophic vaginitis, Cancer of bladder, prostate, brain, or spine, tabes dorsalis **[from record or exam]**.
- **Abnormal Lab Values:** High blood calcium, High blood glucose, Low B_{12}, High BUN or Creatinine **[P9; from record]**.

Final evaluation if incontinence persists:

- **Specific Tests:** Post Void Residual, bladder stress test for females, reflux test (kidney ultrasound for males with PVR>100 ml.) [**Note:** Tests not indicated when Comatose **[B1]** or when No memory recall **[B3e]** AND Dependent in Transfer, Locomotion **[G1b,c,d,e,f]** are both present].

Final evaluation for residents with indwelling catheters: If indwelling catheter **[H3d],** do Voiding Trial unless Untreatable urethral blockage **[I3]**, terminal illness **[J5c],** or stage 3 or 4 pressure ulcer **[M2a]** present.

7. RESIDENT ASSESSMENT PROTOCOL: PSYCHOSOCIAL WELL-BEING

I. PROBLEM

Well-being refers to feelings about self and social relationships. Positive attributes include initiative and involvement in life; negative attributes include distressing relationships and concern about loss of status. On average, 30% of residents in a typical nursing facility will experience problems in this area, two-thirds of whom will also have serious behavior and/or mood problems. When such problems coexist, initial treatment is often focused on mood and behavior manifestations. In such situations, treatment for psychosocial distress is dependent on how the resident responds to the primary mood/behavior treatment regimen.

II. TRIGGERS

Well-being problem (P) or need to maintain psychosocial strengths (S) suggested if one or more of following present:

- Withdrawal from Care/Activities (*Problem*)*
  [E1o = 1,2]
- Conflict with Staff (*Problem*)
  [F2a = checked]
- Unhappy with Roommate (*Problem*)
  [F2b = checked]
- Unhappy with Other Resident (*Problem*)
  [F2c = checked]
- Conflict with Family/Friends (*Problem*)
  [F2d = checked]
- Grief Over Lost Status/Roles (*Problem*)
  [F3b = checked]
- Daily Routine is Very Different from Prior Pattern in the Community *(Problem)*
  [F3c = checked]
- Establishes Own Goals (*Strength*)
  [F1d = checked]
- Strong Identification with Past (*Strength*)
  [F3a = checked]

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* **Note:** This item also triggers on the Mood State RAP.

III. GUIDELINES

Sequentially review the items found on the RAP KEY.

Confounding Problems

Treatments for mood/behavior problems are often immediately beneficial to well-being.

- Does the resident have an increasing or persistently sad mood?
- Does the resident have increasing frequency or daily disturbing behavior?
- Did the mood/behavior problems appear before the reduced sense of well-being?
- Has the resident's condition deteriorated since last assessment?
- Have ongoing treatment programs been effective?

Situational Factors that May Impede Ability to Interact with Others

Environmental and situational problems are often amenable to staff intervention without the burden of staff having to "change the resident."

- Have key social relationships been altered/terminated (e.g., loss of family member, friend or staff)?
- Have changes in the resident's environment altered access to others or to routine activities -- for example, room assignment, use of physical restraints, new dining area assignment?

Resident Characteristics that May Impede Ability to Interact with Others

These items focus on areas where the resident may lack the ability to enter freely into satisfying social relationships. They represent substantial impediments to easy interaction with others and highlight areas where staff intervention may be crucial.

- Do cognitive/communication deficits or a lack of interest in activities impede interactions with others?
- Does resident indicate unease in social relationships?

Lifestyle Issues

Residents can withdraw or become distressed because they feel life lacks meaning.

- Was life more satisfactory prior to entering the nursing facility?
- Is resident preoccupied with the past, unwilling to respond to the needs of the present?
- Has the facility focused on a daily schedule that resembles the resident's prior lifestyle?

Additional Information to Clarify the Nature of the Problem

Supplemental assessment items can be used to specify the nature of the well-being problem for residents for whom a well-being care plan is anticipated. These items represent topics around which to phrase questions and to establish a trusting exchange with the resident. Each item includes the positive and negative end of a continuum, representing the possible range that staff can use in thinking about these issues. Staff can use or not use the items in this list. For those items selected, the following issues should be considered:

- How do staff/resident perceive the ***severity*** of the problem?
- Has the resident ever demonstrated (while in the facility) ***strengths*** in the area under review?
- Are corrective strategies now being used? Have they been used in the past? To what effect?
- Is this an area that might be improved?

7. PSYCHOSOCIAL WELL-BEING RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

Well-being problem or need to maintain psychosocial strengths suggested if one or more of following present:

- Withdrawal from Activities of Interest (*Problem*)*
  [E1o = 1, 2]
- Conflict with Staff (*Problem*)
  [F2a = checked]
- Unhappy with Roommate (*Problem*)
  [F2b = checked]
- Unhappy with Other Resident (*Problem*)
  [F2c = checked]
- Conflict with Family/Friends (*Problem*)
  [F2d = checked]
- Grief Over Lost Status/Roles (*Problem*)
  [F3b = checked]
- Daily Routine is Very Different from Prior Pattern in the Community (*Problem*)
  [F3c = checked]

- Establishes Own Goals (*Strength*)
  [F1d =checked]
- Strong Identification with Past (*Strength*)
  [F3a = checked]

* **Note:** This item also triggers on the Mood State RAP.

GUIDELINES

Confounding problems:

- Increasing/Persistent Sad Mood **[E2, E3]**
- Increasing/Daily Disturbing Behavior **[E4, E5]**
- Resident's Condition Deteriorated Since Last Assessment **[Q2]**

Situational factors that may impede ability to interact with others:

- Loss of Family Member, Friend, or Staff Close to Resident **[F2f, from record]**
- Initial Use of Physical Restraints **[P4]**
- New Admission **[AB1, A4a]**, Change in Room Assignment **[A2]** or Change in Dining Location or Table Mates **[from record]**

Resident characteristics that may impede ability to interact with others:

- Delerium/Cognitive Decline **[B5, B6]**
- Communication Deficit/Decline **[C4, C5, C6, C7]**
- Not at Ease Interacting with Others **[F1a]**
- Locomotion deficit/use of wheelchair **[G1c-f, G5b,c,d]**
- Diseases that Impede Communication – Mental Retardation **[AB10]**, Alzheimer's **[I1q]**, Aphasia **[I1r]**, Other Dementia **[I1u]**, Depression **[I1ee]**
- Uninvolved Activities **[N2, N4]**

Lifestyle issues:

- Incongruence of Current and Prior Style of Life **[AC, F3c]**
- Strong Identification with Past Roles/Status **[F3a]**
- Length of Time Problem Existed **[from record]**

Supplemental problem clarification issues (from resident/family if necessary):

- Ability to Relate to Others
  - Skill/unease in Dealing with Others
  - Reaches Out/Distances Self
  - Friendly/Unapproachable
  - Flexible/Ridiculed by Others
- Relationships Resident Could Draw On
  - Supported/Isolated
  - Many Friends/Friendless
- Dealing with Grief
  - Moving Through Grief/Bitter and Inconsolable
  - Religious Faith/Feels Punished

8. RESIDENT ASSESSMENT PROTOCOL: MOOD STATE

I. PROBLEM

Depression and other mood disorders are common in nursing facility residents, but are often under-diagnosed and under-treated. Such signs are often expressed as sad mood, feelings of emptiness, anxiety, or uneasiness. They are also manifested in a wide range of bodily complaints and dysfunctions, such as loss of weight, tearfulness, agitation, aches and pains.

II. TRIGGERS

A mood problem suggested if one or more of following present:

- Resident Made Negative Statements
  [E1a = 1, 2]
- Repetitive Questions
  [E1b = 1, 2]
- Repetitive Verbalizations
  [E1c = 1, 2]
- Persistent Anger with Self or Others
  [E1d = 1, 2]
- Self-Deprecation
  [E1e = 1, 2]
- Expressions of what Appear to be Unrealistic Fears
  [E1f = 1, 2]
- Recurrent Statements that Something Terrible is About to Happen
  [E1g = 1, 2]
- Repetitive Health Complaints
  [E1h = 1, 2]
- Repetitive Anxious Complaints/Concerns
  [E1i = 1, 2]
- Unpleasant Mood in Morning
  [E1j = 1, 2]
- Insomnia/Change in Usual Sleep Pattern
  [E1k = 1, 2]
- Sad, Pained, Worried Facial Expressions
  [E1l = 1, 2]
- Crying, Tearfulness
  [E1m = 1, 2]
- Repetitive Physical Movements[(a)]
  [E1n = 1, 2]
- Withdrawal from Activities of Interest[(b)]
  [E1o = 1, 2]

- Reduced Social Interaction
  [E1p = 1, 2]
- Mood Persistence
  [E2 = 1, 2]

(a) **Note:** This item also triggers on the Psychotropic Drug Use RAPs when psychotropic drug use present.

(b) **Note:** This item also triggers on the Psychosocial Well-Being RAP.

III. GUIDELINES

Specific conditions stated below suggest the need for an altered/new care strategy. They are not exhaustive; other situations may arise in which staff decides that an altered care plan is necessary. The most obvious are instances of drug-induced side effects (addressed in Psychotropics Drug Use RAP). Residents whose mood problems do not call for care plan alterations are those with stable behavior and no unusual confounding problems.

Many of the questions and issues that follow relate to the MDS items listed on the Mood State RAP KEY. An altered care strategy is suggested when specified conditions are met.

Indicators of the need to consider a new/altered care strategy:

Has Mood Recently Declined or Problems Intensified?

- Were mood problems present 6 months ago?
- Does resident have a cyclic history of decline and improvement in mood state?
- Has loss of appetite with accompanying weight loss occurred?
- Has interest in activities declined, even though resident remains physically capable?

<u>Mood Unimproved and Potentially Reversible Causes Present</u>

Resolution of delirium (fluctuating consciousness) behavioral, relationship and/or communication problems often affect a resident's mood state. Only when these conditions have been addressed can the nature of a mood problem be fully understood.

Also, consider the possible presence of other complicating factors, such as:

- Delirium.
- Review recent changes in the life of the resident (e.g., death of a child, transfer to new environment, separation from loved ones, loss of functional abilities or change in body image, loss of autonomy).
- Review nature and intensity of relationship and/or behavior problems.

ADL decline can be both a cause <u>and</u> a consequence of distressed mood. Reviewing the sequence of ADL and mood decline may be informative. In any case, where mood seems to

impair ADL functioning, useful strategies include modifying the physical environment, separating the resident's performance of ADL activities into a series of subtasks, and using verbal reminders and cues.

- Review record to determine whether there has been a sudden onset or worsening of cognitive symptoms or communication skills following initiation of treatment (e.g., medications).
- Review to determine whether or not the resident is using any medications known to cause mood shifts, such as psychotropics; antihypertensives, such as clonidine (Catapres), quanethedine (Ismelin), methlydopa (Aldomet), propeneral (Inderal), reserpine; cimetidine (Tagamet); cytoxic agents; digitalis; digoxin, lanoxin; immunosuppressives; sedatives; steroids; stimulants.

Mood Unimproved and Other Conditions to Consider

The passive resident with distressed mood may be overlooked. Such a resident may be erroneously assumed to have no mood state problem.

- Does the resident show little/no initiative?
- Does he/she remain uninvolved in activities (alone or with others)?
- Is the sad mood persistent?

Does Sad Mood Appear to Respond to Treatment (e.g., Drug Regimen)?

- Has the mood problem remained relatively unchanged for the last 90 days, or has it improved with the current treatment program?
- Have there been cycles of decline and improvement?
- Is resident receiving medications and/or psychosocial therapy?

Confounding Issues:

Are There Indications of New or Intensified Problems With Conditions That May Affect Mood Problems?

These conditions include: Alzheimer's Disease, cancer, cardiac disease, metabolic and endocrine disorders (e.g., hypercalcemia, Cushing's disease, Addison's disease, hypoglycemia, hypokalemia, porphyria), Parkinson's disease, stroke, or other neurological disease, and thyroid disease.

8. MOOD STATE RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

A mood problem suggested if one or ore of following present:

- Resident Made Negative Statements **[E1a= 1, 2]**
- Repetitive Questions **[E1b = 1, 2]**
- Repetitive Verbalizations **[E1c = 1, 2]**
- Persistent Anger with Self or Others **[E1d = 1, 2]**
- Self Depreciation **[E1e = 1, 2]**
- Expressions of What Appear to be Unrealistic Fears **[E1f = 1, 2]**
- Recurrent Statements that Something Terrible is About to Happen **[E1g = 1, 2]**
- Repetitive Health Complaints **[E1h = 1, 2]**
- Repetitive Anxious Complaints/Concerns **[E1i = 1, 2]**
- Unpleasant Mood in Morning **[E1j = 1, 2]**
- Insomnia/Change in Usual Sleep Pattern **[E1k = 1, 2]**
- Sad, Pained, Worried Facial Expressions **[E1l = 1, 2]**
- Crying, Tearfulness **[E1m = 1, 2]**
- Repetitive Physical Movements[(a)] **[E1n = 1, 2]**
- Withdrawal from Activities of Interest[(b)] **[E1o = 1, 2]**
- Reduced Social Interaction **[E1p = 1, 2]**
- Mood Persistence **[E2 = 1, 2]**

[(a)] **Note:** This item also triggers on the Psychotropic Drug Use RAPs when psychotropic drug use present.

[(b)] **Note:** This item also triggers on the Psychosocial Well-Being RAP.

GUIDELINES

Indicators of the need to consider a new/altered care strategy:

- Mood Decline **[E3]**
- Mood Unimproved **[E3]** and Reversible Conditions Present
  - Recent Move Into/Within Facililty **[AB1, Record]**
  - Delerium **[B5]** Cognitive Decline **[B6]**, Delusions **[**J1e**],** Hallucinations **[J1i]**
  - Communication Decline **[C7]**
  - Grief Due to Loss **[F2f]**
  - ADL Decline **[G9]**
  - Use of Meds known to cause mood shifts (e.g., Antihypertensives, Cimetidine, Clonidine, Cytoxic Agents, Sigitalis, Guanethidine, Immuno-suppressive, Methyldopa, Nitrates, Propranolol, Reserpine, Steroids, Stimulants)
- Mood Unimproved **[E3]** AND Indication of Problem with Cognitive Ability/ Memory, Decision-Making Ability, and Ability to Understand **[B2, B4, C6]** AND ANY of Following:
  - Little or No Initiative Shown **[F1]**
  - Little or No Involvement in Activities **[N2]**
  - No Psychotropic Medications **[O4a,b,c]**
  - No Psychological Therapy **[P1be]**
- Behavioral or Relationship Problems present **[E4, F2]**

Confounding issues to be considered:

- Communication Skills **[C4, C5, C6]**
- **Diseases:** Thyroid Disease **[I1b,c]**, Cardiac Disease **[I1d-I1k]**, Neurological Disease **[I1q to cc]**, Anxiety **[I1dd]**, Depression **[I1ee]**, Manic Depression **[I1ff]**, Schizophrenia **[I1gg]**, Cancer **[I1pp]**, Other Psychosis **[I3]**, Hypercalcemia, Cushing's, Addison's, Hypoglycemia, Hypokalemia, Porphyria **[I3]**

9. RESIDENT ASSESSMENT PROTOCOL: BEHAVIORAL SYMPTOMS

I. PROBLEM

Many residents in a nursing facility may exhibit emotional, social, and/or behavior disorders; some have purely behavioral symptoms (i.e., wandering, verbal abuse, physically aggressive and/or socially inappropriate behaviors). Residents with behavioral symptoms also frequently have other related problems. Those who have behavioral symptoms may have some type or cognitive deficit; others will have mood and/or relationship problems.

Behavioral symptoms are often seen as a source of danger and distress to the residents themselves and sometimes to other residents and staff. It is important to address behavioral symptoms for several reasons. Behaviors are often the only means some residents have for communicating health problems, discomfort, personal needs, preferences, or fears. To ignore such communication attempts by the resident may further isolate someone already burdened by the physical and cognitive losses associated with Alzheimer's disease or other types of dementia. Residents with behavioral symptoms represent a risk to other residents and staff and are much more likely to be abused or neglected.

II. TRIGGERS

The MDS trigger items identify two types of residents for whom further review is suggested: residents who exhibit the behavioral symptoms of wandering, being verbally abusive, being physically aggressive and/or exhibiting socially inappropriate behavioral symptoms AND residents who have improved behavioral symptoms but who are receiving treatment or intervention that might mask manifestations of the behavior (e.g., decreased wandering because resident restrained).

Review of behavior status suggested if one or more of following present:

- Wandering*
  [E4aA = 1, 2, 3]
- Verbally Abusive
  [E4bA = 1, 2, 3]
- Physically Abusive
  [E4cA = 1, 2, 3]
- Socially Inappropriate
  [E4dA = 1, 2, 3]
- Resists Care
  [E4eA = 1, 2, 3]
- Behavior Improved
  [E5 = 1]

* **Note:** This Item also triggers on the Fall RAP.

III. GUIDELINES

The items in this RAP (and in the RAP KEY) begin with those items that help to draw the distinction between serious behavioral symptoms and others that can be more easily accommodated. This followed by a section on potential causes or factors involved in the manifestation of problem behaviors the resolution, of which might reduce or eliminate the behavior(s).

EVALUATING THE SERIOUSNESS OF BEHAVIORAL SYMPTOMS

The first trigger identifies residents who currently exhibit some type of behavioral symptoms for which additional or new treatment programs may be considered. Not all behaviors need an extensive intervention. Some behaviors neither endanger nor distress the resident or others. For example, many hallucinations and delusions (when not a sign of psychosis or an acute condition such as delirium) are benign. Residents with such behavioral manifestations may be accommodated (e.g., tolerated, behavior rechanneled or redirected) within the environment of the nursing facility. Thus, determining whether or not a particular behavioral manifestation is a problem is an important step and involves determining the nature and severity of the behavior(s) in question and the effects of the behavior(s).

Observing Specific Behavioral Manifestations in the Most Recent 7-Day Period

- Review to determine the intensity, duration, and frequency of behavior problems over the last 7-day and 14-day periods. Did these changes vary over time?
- Is there a pattern to the behavior manifestations based on observations over a 7-14 day time period? (Consider such factors as time of day, nature of the environment, what the resident and others were doing at the time the problem behavior was manifested.)

Identifying Stability/Change in the Nature of Behavioral Problems

Identifying patterns of behaviors over time may help clarify the underlying causes of problem behaviors. For example, such a review may reveal a pattern in which a resident's catastrophic reactions typically occur only in the presence of a particular combination of stressors (e.g., a person who can tolerate large groups for singing but not for meals). Similarly, observing a resident over time may reveal that a resident's seemingly random behaviors are associated with particular events (e.g., yelling/screaming associated with objecting to someone changing the channel during a favored television program; wandering associated with the need to toilet). Addressing the causes of such patterns may reduce or eliminate the behavior.

- How did behavior develop over time? Were problem signs evident earlier in the resident's stay or even earlier in the resident's life?
- Has resident experienced recent changes (e.g., movement to a new unit, assignment of new nonlicensed direct care staff to the unit, change in medication, withdrawal from a treatment program, decline in cognitive status)?

Determine the Ways in Which Behavior Problems Impinges on Other Functioning

Understanding that a behavior can - but does not always - interfere with a resident's self-performance and treatment regimens is useful in considering the need for interventions. This view can also help to ensure that aggressive treatments or interventions (e.g., physical restraints or antipsychotics) are not introduced simply to keep the resident "looking normal."

- Does the behavior endanger the resident? Others? If so, in what ways does it endanger the resident or others?
- Are behavior problems related to daily variations in functional performance? If so, how?
- Does behavior problem lead to resistance to care?
- Does it lead to difficulties dealing with people and coping in the facility?

REVIEW OF POTENTIAL CAUSES OF BEHAVIORAL SYMPTOMS

Many behaviors, however, are problematic for the resident or others. Many are directly associated with acute health conditions, neurological diseases, or psychiatric conditions. Still others originate in the resident's reaction to external factors, such as psychotropic medications, the use of physical restraints, and stressors in the environment (e.g., loud noises, changes in familiar routines). Identifying the various factors involved in the manifestation of behavioral symptoms is critical. Such a process may reveal conditions that can be resolved, thus eliminating or reducing the behavioral symptoms. Further, distinguishing among potential causes or interrelationships is essential to developing an appropriate care plan (e.g., distinguishing between behaviors originating with a neurological condition as contrasted to a psychotic syndrome). Consideration of the items in the Behavioral Symptoms RAP KEY (as well as in related RAPs as indicated) should facilitate this process.

Cognitive Status Problem Interactions

Decision-making ability is a key indicator of effective cognitive skills. Resolving acute confusional state or delirium, a potentially reversible problem, can be critical to behavior management. (See Delirium RAP if a diagnosis or signs and symptoms of delirium are present.)

For many residents with chronic progressive dementia, certain behaviors may continue in spite of remedial treatments or interventions. In some instances, the behaviors will be distressing; however, in many instances behaviors can be accommodated. For example, many residents who wander can be accommodated without restraints in a hazard-free environment. Similarly, the needs and patterns of demanding residents or those with catastrophic reactions can often be anticipated or the most disrupting reactions to the distress alleviated. The Cognitive Loss/Dementia RAP refers to several issues that can be considered for such residents. Thus, that RAP should be completed prior to this RAP on Behaviors for residents who have cognitive problems.

Presence of Mood and/or Relationship Problem Interactions

Mood and relationship problems often produce disturbed behavioral symptoms. If the underlying problems are resolved, the behavior may lessen or stop.

- Does the resident have an unresolved mood state or relationship problem that may lead to behavioral symptoms (e.g., anxiety disorder and agitation; depression or isolation and verbally abusive behavior)? Refer to the Psychosocial Well-Being RAP and to the Mood State RAP.
- Is there an association among mood state, relationship, and behavioral symptoms?
- Can a cause and effect relationship be determined?
- Does the resident experience a sense of frustration because of rejection by family? If so, does this frustration result in the resident verbally abusing staff or other residents?

Relationship Difficulties that May Affect Behavior

- Does the presence or absence of other persons precipitate an event?
- Was a combative act prompted by paranoid delusions about another's motives or actions?
- Did recent loss of loved one, change in staff, an intrafacility move, or placement with a roommate with whom the resident cannot communicate lead to disruptive behavioral symptoms?

Environmental Conditions

A review of the resident's behaviors over time may, as noted earlier, reveal a pattern of behaviors that helps identify the causes of the behaviors. Because environmental conditions often have a profound effect on residents' behaviors, these factors should be given special consideration.

- Are staff sufficiently responsive? Do they recognize stressors for the resident and early warning signs of problem behavior?
- Do staff follow the resident's familiar routines?
- Do noise, crowding or dimly lit areas affect resident's behavior?
- Are other residents physically aggressive?

Illness/Conditions

Sometimes, the onset of acute illnesses and/or the worsening of a chronic illness produce disturbed behaviors. Often identification and treatment of the illness will resolve the problem behavior. In addition, a resident with certain chronic conditions, particularly difficulties in making his/her needs understood or in understanding others may also exhibit problem behaviors that can be eliminated or reduced if more effective methods of communication are adopted by staff and families. Sensory impairments (vision, hearing) may also produce disruptive behaviors that would lessen or disappear if the underlying condition were addressed.

- Can physical health factors close in time to the disturbed behavior be identified (e.g., pain or discomfort from physical conditions such as arthritis, constipation, or headache)?
- Can the observed behavior be associated with an acute illness (e.g., urinary tract infection, other infections, fever, hallucinations/delusions, sleep deprivation, fall with physical trauma, nutritional deficiencies, weight loss, dehydration/insufficient fluids, electrolyte disorder, or acute hypotension)?
- Can the observed behavior be associated with the worsening of a chronic illness (e.g., congestive heart failure, diabetes, psychoses, Alzheimer's disease or other dementia, CVA, or hypoglycemia for a diabetic)?
- What was the role of impaired hearing, vision, or ability to communicate or understand others?

Current Treatment/Management Procedures: Positive and Negative Consequences

A number of treatment or management interventions may affect a resident's behavior. Some may have had a positive effect, while others may exacerbate existing behavioral symptoms - or produce new problems. Both are important to consider in reaching a decision about whether or not to proceed with a care plan intervention. For example, review the resident's interest in, use of, or participation in psychological treatment program(s). This review will be especially important for residents who have recently experienced improved behavioral status. For some residents and some management programs, continuation of treatments may be central to maintaining their newfound control. In other cases, either the interventions can be reduced (at least on a trial basis), or the side effects of the intervention may be so severe that alterations in the treatment regimen should be considered. For example, a drug or restraint program may result in increased confusion and agitation, reduced ADL self-performance, a decline in mood, or a general decrease in the quality of life for the resident. On the other hand, breaking tasks of daily life down into smaller steps that the resident can comprehend and perform may reduce stress and prevent problem behavior.

- Has the resident been evaluated by a psychiatrist, etc.? When?
- Are there indicators that treatments have helped resident gain increased control over life? What were they?
- Can improvement be attributed to an identifiable treatment?
- If behavioral symptoms have decreased, can medication or behavior management programs be withdrawn?
- Is the onset or change of behaviors associated with the start of (or change in prescription of) a medication(s)?
- Is the behavior associated with the use of a physical restraint (e.g., increased agitation and anger)?
- Has the resident received care in a specially designed therapeutic unit?
- Are there special staff training/support programs that focus on managing behavioral symptoms?
- What disciplines are involved? How frequent/consistent is the training?
- Has task segmentation been used to maximize resident involvement?